HOUSE . . . . . No. 2758

By Mr. Pedone of Worcester, petition of Vincent A. Pedone for legislation to extend patient protections to recipients of MassHealth. Health Care Financing.

The Commonwealth of Massachusetts

In the Year Two Thousand and Five.

AN ACT TO EXTEND PATIENT PROTECTIONS TO RECIPIENTS OF MASSHEALTH.

Be it enacted by the Senate and House of Representatives in General Court assembled, and by the authority of the same, as follows:

SECTION 1. M.G.L. CHAPTER 176O as Appearing in the 2002 Official Edition is hereby amended by the deletion of the title and insertion of the following new title: HEALTH INSURANCE AND DIVISION OF MEDICAL ASSISTANCE CONSUMER PROTECTIONS.

SECTION 2. Said Chapter 176O is further amended by the deletion in Section 1 of lines 31 through 39 and the insertion in their place of the following:—

"Carrier", an insurer licensed or otherwise authorized to transact accident or health insurance under chapter 175; a nonprofit hospital service corporation organized under chapter 176A; a nonprofit medical service corporation organized under chapter 176B; a health maintenance organization organized under chapter 176G, the Primary Care Clinician Program or any similar managed care arrangement of the Division of Medical Assistance or its successor entity under M.G.L. Chapter 118E; and an organization entering into a preferred provider arrangement under chapter 176I, but not including an employer purchasing coverage or acting on behalf of its employees or the employees of one or more subsidiaries or affiliated corporations of the employer.

SECTION 3. Said Chapter 176O is further amended by the deletion in Section 1 of lines 62 and 63 and the insertion in their place of the following:—

"Covered benefits" or "benefits", health care services to which an insured or a recipient of services under the Division of Medical Assistance or its successor entity under M.G.L. Chapter 118E is entitled under the terms of a health benefit plan or program.

SECTION 4. Said Chapter 176O is further amended by the deletion in Section 1 of lines 83 through 89 and the insertion in their place of the following:—

"Grievance", any oral or written complaint submitted to the carrier or the Division of Medical Assistance or its successor entity under M.G.L. Chapter 118E which has been initiated by an insured or a recipient of public assistance, or on behalf of an insured or recipient of public assistance with the consent of the insured or the recipient, concerning any aspect or action of the carrier or the Division of Medical Assistance or its successor entity under M.G.L. Chapter 118E relative to the insured or the recipient, including, but not limited to, review of adverse determinations regarding scope of coverage, denial of services, quality of care and administrative operations, in accordance with the requirements of this chapter.

SECTION 5. Said Chapter 176O is further amended by the deletion in Section 1 of lines 90 through 92 and the insertion in their place of the following:—

"Health benefit plan", a policy, contract, certificate or agreement entered into, offered or issued by a carrier to provide, deliver, arrange for, pay for, or reimburse any of the costs of health care services; or a managed care arrangement of the Division of Medical Assistance or its successor entity under M.G.L. Chapter 118E.

SECTION 6. Said Chapter 176O is further amended by the deletion in Section 1 of lines 105 through 109 and the insertion in their place of the following:—

"Insured", an enrollee, covered person, insured, member, policyholder or subscriber of a carrier, including an assistance recipient of the Division of Medical Assistance, and including an individual whose eligibility as an insured of a carrier is in dispute or under review, or any other individual whose care may be sub-

ject to review by a utilization review program or entity as described under other provisions of this chapter.

SECTION 7. Said Chapter 176O is further amended by the deletion in Section 2 of lines 1 through 3 and the insertion in their place of the following:—

Section 2. (a) There is hereby established within the division a bureau of managed care. Said bureau shall by regulation establish minimum standards for the accreditation of carriers, other than the Division of Medical Assistance or its successor entity under M.G.L. Chapter 118E, in the following areas:

SECTION 8. Said Chapter 176O is further amended by the deletion in Section 8 of lines 1 through 8 and the insertion in their place of the following:—

Section 8. A carrier, other than the Division of Medical Assistance or its successor entity under M.G.L. Chapter 118E, neglecting to make and file its annual statement or the materials required by the commissioner to be filed with the division under this chapter or under chapter 176G in the form and within the time required thereby shall be fined $5,000 for each day during which such neglect continues after being notified by said commissioner of such neglect, and, after notice and a hearing by the commissioner to that effect, its authority to do new business shall cease while such neglect continues

SECTION 9. M.G.L. Chapter 118E Section 38 as appearing in the 2002 Official Edition is hereby amended by insertion at the end thereof of the following new paragraphs:—

"Within 45 days after the receipt by the Division of completed forms for reimbursement to a physician who participates in a medical service program established pursuant to this chapter, or within 15 days if such claim is received electronically, the Division shall (i) make payments for such services provided by the physician that are services covered under such medical assistance program and for which claim is made, or (ii) notify the physician in writing or by electronic means, within 15 days for written claim forms or 48 hours for electronic claims, of any and all reasons for non-payment, or (iii) notify the physician in writing or by electronic

means, within 15 days for written claim forms or 48 hours for electronic claims, of all additional information or documentation that is necessary to establish such physician's entitlement to such reimbursement. If the Division fails to comply with the provisions of this paragraph for any such completed claim, the Division shall pay, in addition to any reimbursement for health care services provided to which the physician is entitled, interest on any unpaid amount of such benefits, which shall accrue beginning 45 days after the Division's receipt of request for reimbursement, or 15 days after the receipt of an electronic claim, at the rate of 1.5 per cent per month, not to exceed 18 per cent per year. The provisions of this paragraph relating to interest payments shall not apply to a claim that the Division is investigating because of suspected fraud."

"The division shall provide written guidelines to providers of medical services that participate in a medical assistance program established pursuant to this chapter setting forth a statement of its policies and procedures that is complete, detailed and specific with regard to what such providers must include in claims for reimbursement in order to qualify as a completed claim for reimbursement payment for which any such provider is entitled. Such guidelines shall identify all of the data and documentation that is to accompany each claim for reimbursement and shall identify all utilization review and other screening policies and procedures employed by the division in reviewing such claims submitted by a provider of medical services.

"The Division shall, in its payment to physicians, recognize the use of modifiers to billing codes employed by the Division. Modifiers that indicate that a procedure or service is distinct or separate from other services performed on the same day, including services provided in a separate session or encounter; a different procedure or surgery; a different site, or a separate lesion, or separate injury or site of injury shall be reimbursed in a manner consistent with that of programs providing health coverage under Title XVIII of the Social Security Act. Modifiers that identify a significant, separate evaluation and management service by the same physician on the same day of another, non-comprehensive, billed service or procedure shall be recognized by the Division and be compensated in a manner consistent with that of programs providing

health coverage under Title XVIII of the Social Security Act. In implementation of the provisions of this paragraph, the Division shall use the Medicare Correct Coding Initiative standards for modifiers 25 and 59."

The Division shall institute no policy or practice of recoupment, reduction, review or retroactive denial of payments to any physician or physicians for services provided one year or more prior to the date of the Division's initiating said policy or practice. Physicians must be given written notice by the Division specifying any and all policy changes which may result in recoupments, reductions or reviews of payments for physician services at least 90 days prior to the implementation of such recoupments, reductions or reviews.